

# Marketing and Member Education Companion Guide

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# Marketing and Member Education Plan

## Marketing Elements of the Plan

### *Specific Goals*

List each specific marketing **goal** and each **strategy** related to that goal that the MCO intends to pursue during the contract year. If additional goals or strategies are formulated later in the year, an updated Marketing and Member Education Plan should be submitted.

#### Goal

Please summarize each goal in a single phrase or sentence. Then describe the goal and why it is a goal in a short paragraph.

#### Strategy

For each goal, list and describe the strategies the MCO will use to achieve the goal.

### *Informational needs*

Describe how the MCO will meet the informational needs, relative to marketing, for the physical and cultural diversity of the service area. Be sure to include information about any provisions for non-English speaking prospective enrollees, interpreter services and alternate communication mechanisms (such as sign language, Braille or audio tapes).

### *Subcontractors*

List the organization and primary contact name for all subcontractors engaged in marketing activities.

### *Compensation of staff involved in marketing*

Please describe the basis for awarding bonuses or increasing salary of marketing representatives and employees involved in marketing.

### *Material Management*

Detail how current materials will be supplied to service regions, as well as the MCO's plans to remove outdated materials in public areas.

### *Marketing Compliance*

Detail the procedure for monitoring and enforcing compliance with all marketing and member education guidelines, in particular the monitoring of prohibited marketing methods among internal staff and contractors. Procedures for unsolicited direct contact should include circumstances that will initiate referral to the Enrollment Broker; circumstances that will initiate referral to the Medicaid Customer Service Line (toll free # 1-888-342-6207); circumstances that will terminate the encounter; and circumstances that will prompt the MCO to distribute materials to the potential member. Also include a draft of those materials (which must refer all enrollment inquiries to the Enrollment Broker).

### *Attachment A- Copies of Marketing Materials*

Copies of marketing materials, print and multimedia, planned for distribution by the MCO or any of its subcontractors. During the initial contract year this should include previously approved materials for MCOs currently contracted with LDH. Indicate if a material is in a draft form ready for review by LDH. For new contractors, sample materials from other contracts may be submitted. Once the Louisiana Medicaid appropriate version is complete, it should be resubmitted for review.

### *Attachment B – Training Curriculum*

A copy of the MCO training curriculum for marketing representatives (both internal and subcontractor).

#### *Member Education Elements of the Plan*

##### *Specific Goals*

List each specific member education **goal** and each **strategy** related to that goal that the MCO intends to pursue during the contract year. If additional goals or strategies are formulated later in the year, an updated Marketing and Member Education Plan should be submitted.

##### *Goal*

Please summarize each goal in a single phrase or sentence. Then describe the goal and why it is a goal in a short paragraph.

##### *Strategy*

For each goal, list and describe the strategies the MCO will use to achieve the goal.

##### *Informational needs*

Describe how the MCO will meet the informational needs, relative to member education, for the physical and cultural diversity of the service area. Be sure to include information about any provisions for non-English speaking prospective enrollees, interpreter services and alternate communication mechanisms (such as sign language, Braille or audio tapes).

##### *Subcontractors*

List all subcontractors engaged in member education activities.

##### *Patient Engagement Tools*

Please describe current and planned patient engagement tools, such as smartphone-based support programs, as well as texting programs.

### *Attachment C – Copies of Member Education Materials*

Copies of member education materials, print and multimedia planned for distribution by the MCO or any of its subcontractors. This includes previously approved materials for MCOs currently contracted with LDH. Indicate if a material is in a draft form ready for review by LDH. For new contractors, sample materials from other contracts may be submitted. Once the Louisiana Medicaid appropriate version is complete, it should be resubmitted for review.

### *Attachment D*

Both marketing and member education events should be submitted as part of the marketing plan, following the template for the quarterly report, including goal/strategy references, planned events and materials. If referenced materials are planned, but not yet developed, a working title and description of the material should be used. ALL materials the MCO intends to use during the calendar year should be listed (make sure distribution method is captured on the quarterly report for materials). Sponsorship and media events must be approved prior to the sponsorship or event. Submit the distribution schedule for all materials, including media schedules for electronic or print advertising (include date and station or publication).

## Template

Marketing and Member Education Plan

Health Plan:

Date:

Contract Period:

- I. Marketing
  - a. Specific Goals
    - i. Marketing Goal #1: Click here to enter text.
      - 1. Strategy: Click here to enter text.
      - 2. Strategy: Click here to enter text.
    - ii. Marketing Goal #2: Click here to enter text.
      - 1. Strategy: Click here to enter text.
      - 2. Strategy: Click here to enter text.

[Add additional lines as necessary.]
  - b. Informational Needs  
Click here to enter text.
  - c. Subcontractors
  - d. Compensation of staff involved in marketing  
Click here to enter text.
  - e. Material Management  
Click here to enter text.  
Click here to enter text.
  - f. Marketing Compliance
    - i. Unsolicited Direct Contact
    - ii.
- II. Member Education
  - i. Member Education Goal #1: Click here to enter text.
    - 1. Strategy: Click here to enter text.
    - 2. Strategy: Click here to enter text.
  - ii. Member Education Goal #2: Click here to enter text.
    - 1. Strategy: Click here to enter text.
    - 2. Strategy: Click here to enter text.
  - b. Informational Needs
  - c. Subcontractors
  - d. Patient Engagement Tools

# Style Guide

## Introduction

### Consistency, Quality, Time Savings

This guide has been created to provide guidance to MCOs submitting marketing and member education materials for review and approval. It is intended to foster consistency of review, as well as encourage quality and adherence to health literacy standards. Proper use of this guide may result in time savings for the MCO, as fewer materials will require revision prior to final LDH approval.

### Using This Guide

Please refer to this guide when creating materials as well as reviewing materials prior to submission to LDH for review.

This guide includes both required and suggested guidance. Suggestions are preferred, but not required. If you submit materials that deviate from the guide, please be sure to explain the reasoning behind the deviation in a comment. This will facilitate a quick review, and help keep questions to the MCO to a minimum.

This guide is a living document and will be updated as needed.

## General

### All Materials

#### *Font Size*

All written materials must be clearly legible with a minimum font size of twelve-point, with the exception of Member ID cards.

#### *Person First Language*

All written materials must be in accordance with the [LDH "Person First" Policy](#).

For additional guidance refer to the National Center on Disability and Journalism's [style guide](#) and the Research and Training Center on Independent Living's ["Guidelines for Reporting and Writing about People with Disabilities."](#)

#### *Reading Level*

In general the writing should be at no higher than a 6.9 grade level, taking into consideration the need to incorporate and explain certain technical or unfamiliar terms to assure accuracy. This applies to any releases or disclaimers.

While reading level is important, equally important is using plain language. A reading level score can be easily altered by excluding words. To prevent improper exclusions please ONLY exclude the following when calculating the reading level:

- The MCO's name
- Proper Names (including: drug names, procedure names, and similar)
- Medicaid
- Medical terms with 3+ syllables
- Phone numbers

- Addresses (physical, mailing, or e-mail)
- Member ID
- Dates

Everything else should be included in the reading level calculation.

## Marketing Materials

### *Enrollment Materials*

#### *Choose, Pick, Join, etc.*

The MCO and its subcontractors are prohibited from using terms in marketing materials such as “choose,” “pick,” “join,” etc. unless the marketing materials include the Enrollment Broker’s contact information.

#### *General Information is accurately reflected*

Marketing materials must accurately reflect general information, which is applicable to the average potential enrollee of the MCO.

#### *MCO Contact Information*

The MCO’s name, mailing address (and physical location, if different) and toll-free number must be prominently displayed on the cover of all multi-paged marketing materials.

## Member Materials

### *Oral Interpretation Services*

All multi-page written member materials must notify the member that real-time oral interpretation is available for any language at no expense to them, and how to access those services

### *Version Information*

The MCO shall include in all member materials the following: the date of issue, the date of revision, and/or if the prior versions are obsolete.

## Consistency across Plans

To promote health literacy for members and to enable equitable review of materials please use the following guidance in all communications with members and nonmembers alike.

### *“Plain Language”*

Documents should be written in the active voice and should address the reader directly. The content should be limited to what the reader needs to know and should provide necessary background. The words used should be everyday words arranged into simple sentences. If a word is used that the reader may not understand it should be explained and an example should be provided. The overall tone of the document should be friendly.

### *Acronyms and Initialisms*

Many people working in or with large organizations are all too familiar with the alphabet soup of abbreviated terms for groups, programs or offices with which they work.

When writing such terms it is important to remember to always identify the full name for the abbreviated term first and to reference the abbreviation that will be used in its place in parentheses. In longer documents or documents with several abbreviations, it may be necessary to restate the full term and reprint the abbreviation in parenthesis again to refresh the reader on the term's meaning.

- Example: The pilot program report will be written by the Department of Defense (DOD). The DOD will be responsible for providing quarterly updates to the pilot program report for the next two fiscal years.

It is also important to distinguish between the two types of abbreviated terms and to understand the different ways they are used.

- Acronym: an abbreviation formed from the initial letters of other words and pronounced as a word rather than as the separate letters forming the abbreviation. Examples include GOHSEP, NASA and NATO.
  - Acronyms do not retain a definite article (*the*) even if their full names have them. Thus, the North Atlantic Treaty Organization is referred to as "NATO" and not "the NATO."
- Initialism: an abbreviation consisting of initial letters pronounced separately rather than as word. Examples include the U.N., the WTO and the DOD.
  - Initialisms retain the definite article if their full names have them.
  - Exceptions can be made depending on the branding of an individual organization. Thus, the Louisiana Department of Health is referred to as "LDH" and not as "the LDH."

#### *Alternate Spellings*

If a word has more than one accepted spelling, please use the simplest spelling. In the case of preventative and preventive, preventive is preferred. Similarly, health care is preferred over healthcare.

#### *Pronouns for consistency*

Pronouns should be used consistently throughout the document (example: When referring to the MCO's provider network always use *our network* or always use *your network*. Do not switch between the two.)

#### *Pronouns for readability*

Once the MCO has been identified, use a pronoun in subsequent references to the MCO, unless it would add confusion. (example: You recently received a letter from LDH. We want to make sure you are taking care of yourself.)

#### *Friendly Tone*

The tone of materials should be kept friendly and conversational.

#### *Organizational Aids*

Organize the document in sections. Use navigational aids such as headings, or a question and answer format to help readers skim the document. Link similar messages by repeating key words or concepts from a previous section.



When giving instructions, the instructions should be numbered and listed in the order they should occur. Instructions should also begin with an action verb.

#### *Format*

Suggested line length: 7 – 15 words. The material has a similar style and structure throughout. Font usage is consistent. Fonts are easy to read, not fancy or unusual. Italics and bold should be used sparingly. Include page numbers on multi-page documents. Print density vs. white space. Uncluttered layout. Dark colored type on a light background.

#### *Divided words*

Avoid layouts which necessitate words to be divided.

### Required

#### *Referring to Medicaid Managed Care*

When referring to the MCOs collectively they should be referred to as Medicaid health plans.

#### *Healthy Louisiana*

Healthy Louisiana is a term intended to encompass all full-coverage Medicaid programs and the delivery of the services they offer.

#### *Call Scripts*

##### *All Call Scripts*

##### *Verification Guidance*

Two unique identifiers must be confirmed before PHI is discussed over the phone. The information must be supplied by the member. These unique identifiers should NOT be the member's Social Security Number or Member Identification Number.

##### *Procedure for the possibility the member is not verified*

Instruction as to what to do in the event verification is not obtained should be included in all call scripts where PHI is discussed.

##### *Member Demographics*

If a member reports a demographic change the MCO should report changes to LDH, as prescribed by LDH.

##### *Outbound Call Scripts*

##### *Messages*

Messages should not include any PHI as member verification has not been obtained.

#### *Central Time*

When a time is stated in a document it should always be stated in Central Time. However, the phrases: "Central Time," "Central Standard Time," "Central Daylight Savings Time," "CT," "CST,"

or “CDT” should not be used. All of Louisiana is located in the Central Time zone. References to it are therefore unnecessary.

#### *Member Services*

Include the phone number and operating hours when directing the reader to contact Member Services. If the information is given elsewhere on the same page this is preferred, but not required.

#### *Phone numbers*

Phone numbers should be verified before a material is submitted to LDH for review. Periods should not be used in place of dots in phone numbers when published online. Doing so disables the touch-and-call function on mobile devices.

#### *Toll-Free Numbers*

Toll-Free numbers should include the leading 1. (Examples: 1-855-229-6848, 1.888.342.6207)

#### *Value Added Benefits*

Value added benefits and contractually mandated benefits may both be used in the same document, but mandated benefits may not be described as “extra” or “additional” benefits.

### Preferred

#### *Use of the word Free*

When possible, LDH prefers the term be avoided. Further guidance is as follows:

##### *As related to contractually obligated services*

The term free should not be used to describe services which are obligated by the contract between LDH and the MCO. The MCO receives remittance for all such services in the form of the per member per month payments.

##### *As related to value added benefits*

Value added benefits, as defined in this document, may be referred to as free.

##### *As related to toll-free numbers*

The word free can be used to describe a toll-free number.

### Consistency within a Document

#### Required

##### *Internet and Web Styles*

When referring to an internet site please be consistent in the address. Avoid using all the possible styles of address in a single document. Please limit to a single style within a single document.

- <http://www.google.com>
- [www.google.com](http://www.google.com)
- [Google.com](http://www.google.com)

#### *Consistent Usage of the Same Term*

Sometimes there are multiple ways to refer to the subject of a letter or brochure (Example: drug store vs. pharmacy). When that is the case, please use the same term throughout the document.

#### Preferred

#### *Layout with Multiple Languages*

When multiple languages are used in the same document, the order in which they appear should remain consistent throughout the document. If the English version is first and the Spanish translation follows, that should be the case anywhere in the document where both languages are present.

## Material Approval Process

All proposed materials must be submitted via email to [MMEReview@la.gov](mailto:MMEReview@la.gov). LDH will review the submitted materials and inform the MCO via email of approval, denial or necessary changes.

## Media Events/Sponsorship Approval Process

All proposed sponsorships, media events and media activities must be submitted via email to [MMEReview@la.gov](mailto:MMEReview@la.gov). LDH will review the submitted sponsorships and inform the MCO via email of approval, denial or necessary changes.

## Medicaid Enrollment Event Notification Process

Application assistance at MCO-hosted events may ONLY be conducted by LDH staff, Marketplace Navigators or Certified Application Centers. MCOs cannot provide application assistance. All MCO hosted events that will include a Medicaid application element must be submitted to LDH via email to [MMEReview@la.gov](mailto:MMEReview@la.gov) once application assistance is secured, and before the event. The email shall include confirmation from Medicaid regional staff of their participation, with particulars of the event or the name and contact information of the Application Center or Marketplace Navigator conducting the assistance.

## Managed Care Terms – Standard Definitions

The MCO should use the following definitions, in accordance with 42 CFR § 438.10(c)(4)(i). Slight departure from the wording below may be accepted, when appropriate in context.

**APPEAL:** A step you can take to ask Medicaid to change its mind when it decides it will not pay for care you need.

**BEHAVIORAL HEALTH SERVICES:** Health care for emotional, psychological, substance use and psychiatric problems. It is part of your health plan.

**CO-PAYMENT:** Money you have to pay out of your pocket before you can see a health provider.

**CONTINUITY OF CARE:** If your primary care provider sends you to a specialist, your primary care provider will stay involved and keep up with all your medical treatments.

**CARE COORDINATION:** Your primary care provider works with you and other providers to make sure that all your providers know about your health problems.

**DURABLE MEDICAL EQUIPMENT:** Equipment ordered by your physician that helps you at home. This includes wheelchairs, hospital beds, canes, crutches, walkers, kidney machines, ventilators, oxygen, monitors, pressure mattresses, lifts, nebulizers, etc.

**EMERGENCY MEDICAL CONDITION:** A health problem that needs immediate medical attention. An example includes a health problem that can cause you (or your unborn child, if you are pregnant) serious harm.

**EMERGENCY MEDICAL TRANSPORTATION:** Ambulance.

**EMERGENCY ROOM CARE:** Care for an emergency medical condition that is too serious to be treated in a clinic or urgent care center.

**EMERGENCY SERVICES:** Inpatient and outpatient medical care by a healthcare provider to screen, evaluate, and/or stabilize your emergency medical condition.

**EXCLUDED SERVICES:** Care that is not paid for by Medicaid.

**GRIEVANCE:** A report that you can make if you are not happy with the quality of care you got or if you think a provider or someone at the clinic was rude or denied you access to the care you needed.

**HABILITATION SERVICES AND DEVICES:** Health care services that help you keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities.

**HEALTH INSURANCE:** A plan that helps you pay for health care visits, procedures, hospital stays and preventive care. It will pay for the high cost expenses and routine screenings that it says are covered.

**HEALTH PLAN:** A group of doctors, hospitals and other providers who work together to help you get the health care services you need. They may provide physical health services, like doctor, hospital and emergency room visits; x-rays and prescriptions, and non-emergency medical transportation. They may also provide mental health or substance use disorder services, like psychotherapy or crisis intervention.

**HEALTH RISK ASSESSMENT:** A form you fill out to tell about your health and health behavior. Health providers use the information to figure out whether you are at risk of getting certain diseases or medical conditions.

**HOME HEALTH CARE:** A wide range of health care given in your home to treat an illness or injury. Examples include care for a wound, patient education, checking your blood pressure and breathing, checking on you after you get out of the hospital.

**HOSPICE SERVICES:** Hospice is to keep you comfortable and as free as possible from pain and symptoms when you have a terminal illness. Hospice helps you have a good quality of life for time remaining. Most hospice care happens at home or it can be given in hospital or special facility. Hospice is for patients likely to die within six months if their disease runs its normal course.

**HOSPITALIZATION:** When you are checked into a hospital for care.

**HOSPITAL OUTPATIENT CARE:** Care given at a hospital that your doctor does not expect will need an overnight stay. In some cases you may stay overnight without being registered as an in-patient. Examples include same-day surgery and blood transfusions.

**MEDICALLY NECESSARY:** Medical care or supplies your provider says are needed to prevent, diagnose or treat your illness, injury, or disease. To be medically necessary, the care or supplies must be clinically appropriate and meet accepted standards of medicine. Medicaid does NOT pay for treatments that are experimental, non-FDA approved, investigational, or cosmetic.

**NETWORK OR PROVIDER NETWORK:** The group of providers linked to your health plan who provide primary and acute health care.

**NON-PARTICIPATING PROVIDER:** A physician that is not part of your provider network.

**PHYSICIAN SERVICES:** Care provided by a physician.

**PLAN:** See Health Plan.

**PREAUTHORIZATION:** Getting permission for specific health services before you receive them so that Medicaid will pay for the care.

**PARTICIPATING PROVIDER:** A provider who works for your health plan or is linked to your health plan.

**PREMIUM:** The amount of money you must pay for your health care plan.

**PRESCRIPTION DRUG COVERAGE:** The medicines your plan will pay for that your provider prescribes that have to be filled by a pharmacy.

**PRESCRIPTION DRUGS:** These are medicines your provider prescribes that have to be filled by a pharmacy.

**PRIMARY CARE PHYSICIAN:** The doctor who is responsible for your health care. This doctor may also refer you to a specialist, or admit you to a hospital.

**PRIMARY CARE PROVIDER:** A physician, nurse practitioner, or physician assistant who manages your health care needs. This includes preventive care and care when you are sick. The primary care provider may treat you, refer you to a specialist, or admit you to a hospital.

**PROVIDER:** An individual, clinic, hospital or other caregiver approved by Medicaid to provide health care.

**REHABILITATION SERVICES AND DEVICES:** Care and items that help restore your health and functions. Examples include cardiac rehab (for your heart), pulmonary rehab (to help you breathe better) and physical or speech therapy. These include exercise, education and counseling. These are usually provided in a hospital outpatient setting but can be offered in a skilled nursing facility.

**SKILLED NURSING CARE:** A high level of nursing care. Nurses help to manage, observe, and evaluate your care.

**SPECIALIST:** A health professional who is educated and trained to have in-depth knowledge of how to care for certain medical problems. Physician specialist examples include cardiologist (heart doctor), pulmonologist (lung doctor), nephrologist (kidney doctor) and surgeon.

**URGENT CARE:** Medical care to treat an illness or injury that needs quick attention but that is not a medical emergency. Examples include stomach pain, dizziness that will not go away, or a suspected broken bone. Urgent care requires face-to-face medical attention within 24 hours of noticing the urgent problem.

## Required Member Materials

Templates for all materials found in this section can also be found online at [www.ldh.la.gov/MME](http://www.ldh.la.gov/MME).

The intention of the templates below is to provide a uniform format to enable members to more easily navigate materials across plans. The templates are encouraged, but not required, unless noted

otherwise. All required materials must be created in formats appropriate to each of the eligibility populations outlined in the MCO Contract.

## Handbook

The intention of this template is to provide a framework for the MCO to elaborate. In addition to the questions listed in the FAQ/Index below, it is recommended each MCO utilize their own Member Services information to determine frequent questions not covered. Information requirements set forth in 42 CFR §438.10(g) must be met. In addition, the following must be included:

- Table of contents;
- A general description about how the MCOs operate, and detailed descriptions of the following:
  - Enrollee rights and responsibilities;
  - Appropriate utilization of services, including ED for non-emergent conditions; and
  - PCP's role as coordinator of services;
- Member's right to disenroll from MCO, including disenrollment for cause;
- The amount, duration, and scope of benefits available to the member under the contract between the MCO and LDH in sufficient detail to ensure that members understand the benefits to which they are entitled, including specialized behavioral health benefits and information about health education and promotion programs, including chronic care management, tobacco cessation and problem gaming;
- Description on the purpose of the Medicaid card and the MCO card, why both are necessary, and how to use them;
- Grievance and appeal procedures that include State Fair Hearing rights, method to obtain, and rules concerning representation at the hearing;
- A description of Advance Directives that includes:
  - The MCO policies related to advance directives;
  - Information that members can file complaints about the failure to comply with an advance directive with the Office of Health Standards, Louisiana's Survey and Certification agency, by calling 225-342-0138; and
  - Information about where a member can seek assistance in executing an advance directive and to whom copies should be given;
- Information to call the Medicaid Customer Service Unit toll free hotline, go to the Louisiana Medicaid website at [www.ldh.la.gov/mymedicaid](http://www.ldh.la.gov/mymedicaid), or visit a regional Medicaid eligibility office to report if family size, living arrangements, parish of residence or mailing address changes;
- How to make, change and cancel medical appointments and the importance of canceling and/or rescheduling rather than being a "no show;"
- Member Services fax number, e-mail address, and mailing address to contact Member Services;
- Information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;
- Information about the requirement that a member shall notify the MCO immediately if he or she has a Worker's Compensation claim, a pending personal injury or medical malpractice law suit, or has been involved in an auto accident;
- Reporting requirements for the member that has or obtains another health insurance policy, including employer sponsored insurance. Such situations shall be reported to the MCO;

- Member responsibilities, appropriate and inappropriate behavior, and any other information deemed essential by the MCO or LDH. This shall include a statement that the member is responsible for protecting their ID card and that misuse of the card, including loaning, selling or giving it to others could result in loss of the member's Medicaid eligibility and/or legal action;
- Information on the member's right to a second opinion in accordance with 42 CFR §438.206(b)(3) at no cost and how to obtain it;
- Information on what to do if a member is billed, and under what circumstances a member may be billed for non-covered services; and
- Any additional text provided to the MCO by LDH or deemed essential by the MCO.



## Title Page

[New Page]

## Table of Contents

[New Page]

## Welcome

- MCO Service Hours and contact information
  - Member Services
  - Nurse Line
  - Crisis Line
  - Dental Benefit Manager
  - Fraud Reporting
  - Pharmacy Benefit Manager
  - Transportation
- State contracts MCOs to provide health coverage to Medicaid and LaCHIP enrollees. MCOs work with providers all across the state including hospitals, doctors, nurse practitioners, therapists and others. This is our network, they are the people members can get their healthcare from. (Include structure/operation of MCO\* and physician incentive plans\* = More information available on request.)
- Utilization – Include Service utilization policies\*. \* = More information available on request.
- Member Rights general plain language description
- PCP role/selection

## Getting Care

- Family/Caregiver/Legal guardian role
- Make/Change/Cancel appointments
- Appointment timeframes
- After Hours care

- Emergency/Crisis
  - Benefit details
  - How to obtain
- PCP/EPSTD services
- Specialty Care
- Right to 2<sup>nd</sup> Opinion
- Right to Refuse Treatment
- Change providers/restrictions in freedom of choice
- Transportation
- Interpretation/Translation
- Pharmacy (including co-pay information)
- Prior Authorization
- Advanced Directives

## **Member Satisfaction**

- Right to Fair Treatment
- Grievance/Appeals
- Bills for covered services
- Report Fraud
- Member Advisory Committee
- Quality Improvement

## **What we pay for**

- Benefit details
- Access services covered by the state plan, but not the MCO
- Access services MCO does not cover due to moral or religious objections
- Utilization details
- Promotion Programs

## **Helping you be healthy**

- Chronic Care Management
- Health Education
  - Tobacco Cessation
  - Problem Gambling

## **Other Plan Details**

- Rights and protections
- HIPAA related information

- Subrogation
  - Notification of a claim
  - Inform MCO of other insurance
- Medical Record requests
- Change plans
- Disenroll
- Marketing Violation

## Medicaid related

- Eligibility
- Demographics changes
  - Toll free
  - Web site
  - Local office

## FAQ/Index

What do I do if...

... I have other insurance now?

[Paragraph Title] .....[Page #]

... I had an accident and was injured?

... I moved?

... I don't like my PCP?

... Someone at the provider's office treated me poorly?

... a health plan representative treated me poorly?

... I don't want the treatment my doctor suggests?

... I don't have a way to get to my appointments?

... I get a bill?

... I can't find a doctor that takes my health plan?

... I think a provider is doing {fraudulent things}?

... I have a pending lawsuit about medical claims?

... I think I'm having an emergency?

... I'm having an emergency?

... I disagree with a provider's recommendation?

... I'm worried about being very sick or unconscious and not able to make my own medical decisions?

... I need to see a doctor?

... I can't make a doctor's appointment?

... I'm in an accident?

... my PCP's office is closed and I think I need help right away?

... I want to help a family member cope with behavioral health conditions?

...I'm feeling overwhelmed by things going on in my life?

...I'm thinking about hurting myself or someone else?

How do I...

... contact Member Services?

... speak with someone in my language at Member Services?

... see a specialist?

... get in touch with Medicaid representatives?

... get an interpreter to help me at appointments with providers?

... get information from the health plan in a different language?

... get information from the health plan in large type?

... get information about how the health plan rewards providers?

... {report marketing violations}?

... get care from behavioral health providers?

... find out more about behavioral health conditions?

- ... find out if my medication is covered?
- ... stop smoking on my own?
- ... get free nicotine packages?
- ... pick a doctor or other provider?
- ... find a dentist near me?
- ... find out if a medication I'm taking is covered?

[Paragraph Title] .....[Page #]

Can I...

- ... change health plans?
- ... change PCPs?
- ... choose a different provider?
- ... choose any provider that is in the network?
- ... get information in my language?
- ... have Medicaid pay for my medical expenses without being in a health plan?
- ... decide what behavioral health information is shared with my family members?

What does...

- ... a PCP do?
- ... a health plan do?
- ... Member Services do?
- ... Medicaid customer service do?
- ...the health plan pay for?

...behavioral health mean?

...behavioral health coverage help me with?

When should I...

... see my PCP?

... call Member Services?

... go to urgent care?

... go to the emergency room?

... call the crisis line?

What happens...

... after I'm treated for an emergency?

... if I need to see a specialist?

... if I don't pick a PCP?

... the health plan doesn't cover a service?

... if I go to the emergency room and the doctors there don't think it was an emergency?

... if a medication I'm taking is no longer covered?

I need...

... an ASL interpreter, how do I arrange for one?

... information in a different language, how do I get it?

... information in a different format (like Braille or large print), how do I get it?

...to go to the dentist, how do I find one near me?

What are...

- ... my rights?
- ... my responsibilities as a member?
- ... behavioral health services?
- ...the warning signs of a gambling problem?

How much...

- ... will my medication cost?
- ... will I have to pay for services?
- ... behavioral health information is shared with my family members?

Do I need...

- ... prior authorization?
- ... two cards?
- ... special permission for my medication?

What should I ...

- .... Expect during a visit?
- ... take with me to an appointment?

[Top 5/10 FAQ from Member Services not covered]

## Welcome Newsletter

The intention of this template is to provide a framework for the MCO to elaborate. The Welcome Newsletter must include information that enables the enrollee to understand how to effectively use the managed care program. This information must include at a minimum:

- Right to request an updated member handbook at no cost to the member. Notification that the handbook is available on the contractor's website, by electronic mail or through postal mailing must be referenced;
- Member grievance and appeal rights;
- Right to access oral interpretation services, free of charge, and how to access them that adheres to the requirements in 42 CFR §438.10(4) and (5);
- MCO service hours and availability with contact information including, but not limited to member services, nurse line, behavioral health crisis line, dental benefit manager, reporting suspected fraud and abuse, pharmacy benefit manager, and transportation;
- Tobacco cessation information with a website link to tobacco education and prevention program
- Information on how to search for providers, including specialized behavioral health providers, and how to obtain, at no charge, a directory of providers;
- Information on what to do if a member is billed, and under what circumstances a member may be billed for non-covered services;
- How to file a grievance;
- What to do in case of emergency, information on proper emergency service utilization, and the right to obtain emergency services at any hospital or other ED facility, in or out of network;
- How to report suspected fraud, waste, and abuse;
- Right to be treated fairly regardless of race, religion, gender, age and ability to pay;
- Right to request a medical record copy and/or inspect medical records at no cost as specified in 45 CFR Part 164;
- How to access afterhours care;
- How to change health plans;
- Instructions on changing a PCP;
- Instructions where to find a detailed listing of covered benefits;
- Identification of services for which copays are applicable; and
- Specialized behavioral health services information, including where and how to access behavioral health services (including emergency or crisis services).
- Problem gambling treatment with a website link to potential resources, such as <http://ldh.la.gov/index.cfm/page/2253>



## Welcome

- Welcome Statement
- MCO Service Hours and contact information
  - Member Services
  - Nurse Line
  - Crisis Line
  - Dental Benefit Manager
  - Fraud Reporting
  - Pharmacy Benefit Manager
  - Transportation
- PCP role/selection

## What we pay for

- Benefit details
  - where to find

## Getting Care

- How to find/choose providers (including Specialized Behavioral Health)
- Make/Change/Cancel appointments
- After Hours care
- Emergency/Crisis
  - Benefit details
  - How to obtain
  - Rights to obtain services out of network
- Change providers/restrictions in freedom of choice, how to get a directory
- Transportation
- Interpretation/Translation
- Pharmacy (including co-pay information)

## **Member Satisfaction**

- Right to Fair Treatment
- Grievance/Appeals
- Bills for covered services
- Report Fraud

## **Helping you be healthy**

- Health Education
  - Tobacco Cessation
  - Problem Gambling

## **Other Plan Details**

- Medical Record requests
- Change plans
- How to request a Member Handbook

## Welcome Letter

The intention of these templates is to provide a format for the MCO to elaborate. The welcome letter must include information highlighting major program features, details that a card specific to the MCO's Medicaid managed care plan will be sent via mail separately and contact information for the MCO's managed care plan.

## Pediatric Template

Welcome to [MCO]. Your [MCO] ID card will be arriving soon. You may even have already gotten it. You will also be getting a Medicaid ID card from LDH. The chart below shows examples of when you should use which card.

### [MCO] ID Card

At the doctor's office  
To pick up prescriptions  
When you call to schedule a ride

### LDH ID Card

Any time you are getting services  
that will be paid for by Medicaid  
or [the MCO]

If you ever need a new card, [MCO specific instructions].

[MCO] is a Medicaid health plan. A health plan is a group of doctors, hospitals and other providers who work together to help you get the health care services you need.

Our services include:

#### Physical Health Services

Doctor visits  
Hospital visits  
Emergency room visits  
X-rays  
Prescriptions  
Non-Emergency medical transportation

#### Mental Health or Substance Use Disorder Services

Psychotherapy  
Crisis Intervention

If you need help understanding something about the health plan, call us at **[Member Services number and hours]**, we're happy to help you. [Interpretation statement]. For a complete list of our services and benefits and your rights and responsibilities, you can go online to [MCO website]. A complete handbook is there in the Members section.

## Adult Template

Welcome to [MCO]. Your [MCO] ID card will be arriving soon. You may even have already gotten it. You will also be getting a Medicaid ID card from LDH. The chart below shows examples of when you should use which card.

### **[MCO] ID Card**

At the doctor's office  
To pick up prescriptions  
At the dentist

### **LDH ID Card**

Any time you are getting services  
that will be paid for by Medicaid  
or [the MCO]

If you ever need a new card, [MCO specific instructions].

[MCO] is a Medicaid health plan. A health plan is a group of doctors, hospitals and other providers who work together to help you get the health care services you need.

Our services include:

#### Physical Health Services

Doctor visits  
Hospital visits  
Emergency room visits  
X-rays  
Prescriptions  
Non-Emergency medical transportation

#### Mental Health or Substance Use Disorder Services

Psychotherapy  
Crisis Intervention

If you need help understanding something about the health plan, call us at **[Member Services number and hours]**, we're happy to help you. [Interpretation statement]. For a complete list of our services and benefits and your rights and responsibilities, you can go online to [MCO website]. A complete handbook is there in the Members section.

## Behavioral Health Only Template

Welcome to [MCO]. Your [MCO] ID card will be arriving soon. You may even have already gotten it. You will also be getting a Medicaid ID card from LDH. The chart below shows examples of when you should use which card.

### **[MCO] ID Card**

At the mental health therapist's office  
For addiction counseling  
When getting crisis Intervention

### **LDH ID Card**

Any time you are getting services that will be paid for by Medicaid or [the MCO]

If you ever need a new card, [MCO specific instructions].

[MCO] is a Medicaid health plan. A health plan is a group of doctors, hospitals and other providers who work together to help you get the health care services you need.

Our services include:

Mental Health or Substance Use Disorder Services  
Psychotherapy  
Crisis Intervention

If you need help understanding something about the health plan, call us at **[Member Services number and hours]**, we're happy to help you. [Interpretation statement]. For a complete list of our services and benefits and your rights and responsibilities, you can go online to [MCO website]. A complete handbook is there in the Members section.

## Member ID Cards

### Template

#### Front

##### Card Front

MCO Logo		
Member Name:	PCP Name:	
DOB:	PCP Address:	
Member ID#:	PCP Phone #:	
Plan ID:	PCP After Hours Phone #:	
Effective Date:		
<hr/>		
Rx BIN:	Rx Group:	Rx PCN:

#### Back

##### Card Back

Important Contact Information	MCO Logo
Member: Please present this card each time before you receive medical care except in an emergency. In case of an emergency, call 911 or go to the closest emergency room.	Providers: Provider Services and Prior Authorization # Pharmacy Services Toll Free #
Members: Member Services Toll Free # / TTY Grievance & Appeals Toll Free # 24/7 Nurse Line Toll Free # Vision Toll Free # Pharmacy Benefits Toll Free #	MCO Address:  Medical Claims Address:  Pharmacy Claims Address:

## Member ID Card Carrier

### Integrated Template

MCO Plan Name

Address Line 1

Address Line 2



<Member Name>

<Address Line 1>

<Address Line 2>

<City><State><Zip>

## Welcome to <MCO Plan Name>!

Here is your new <MCO Plan Name> member ID card:

- Please check the information on your card to make sure it is right.
- To make changes, please call Member Services toll free at 1-XXX-XXX-XXXX.

## Here are some tips for using your <MCO Health Plan Name> member ID card:

- Keep your card in a safe place.
- Carry your <MCO Health Plan Name> member ID card with you at all times.
- If you lose your <MCO Health Plan Name> card, please call 1-XXX-XXX-XXXX.
- If you lose your Louisiana Medicaid Card, please call 1-888-342-6207.
- If you have an emergency, call **911** or go to the closest emergency room.
- For more information on your member benefits and available services, go to <MCO Web site>

## Additional Information:

- If there is a PCP (Primary Care Provider) listed on your card, please call and set up a new patient appointment as soon as possible. It is important to meet your doctor. If you need help scheduling a new patient appointment, contact Member Services at 1-XXX-XXX-XXXX.
- If your card says “No PCP Selected”, please call Member Services to pick a doctor.
- Your medical benefits include mental health and substance use treatment services. It also includes services provided by a psychiatrist, psychologist and mental health rehabilitation provider. If you are in crisis, such as having feelings of hurting yourself or others, or need detox services, call the 24 hour Mental Health and Substance Use Crisis Line at 1-XXX-XXX-XXXX.

## Behavioral Health Only Template

MCO Plan Name

Address Line 1

Address Line 2



<Member Name>

<Address Line 1>

<Address Line 2>

<City><State><Zip>

**Welcome to <MCO Plan Name>!**

**Here is your new <MCO Plan Name> mental health and substance use member ID card:**

- Please check the information on your card to make sure it is right.
- To make changes, please call Member Services toll free at 1-XXX-XXX-XXXX.
- Your medical benefits now include mental health and substance use treatment services. It also includes services provided by a psychiatrist, psychologist and mental health rehabilitation provider.

**Here are some tips for using your <MCO Health Plan Name> member ID card:**

- Keep your card in a safe place.
- Carry your <MCO Health Plan Name> member ID card with you at all times.
- If you lose your <MCO Health Plan Name> card, please call 1-XXX-XXX-XXXX.
- If you lose your Louisiana Medicaid Card, please call 1-888-342-6207.
- If your mental health and substance use provider is unavailable and you are in crisis, such as having feelings of hurting yourself or others, or need detox services, call the 24 hour Mental Health and Substance Use Crisis Line at 1-XXX-XXX-XXXX.
- If you have an emergency, call **911** or go to the closest emergency room.
- For more information on your member benefits and available services, go to <MCO website>.



## Provider Directory

The intention of this template is to provide a framework for the MCO to elaborate. Information requirements set forth in 42 CFR §438.10(h) and the MCO's contract with the LDH must be met. This includes:

### Distribution and accessibility requirements

- Directory available in paper (upon request) and electronic form.
- Directory available on the MCO website in machine readable file and format.
- Updates monthly for paper form and no later than 30 calendar days after the MCO receives updated provider information for the electronic form.

### Network provider information

The provider directory must include the information listed below for providers within the MCO's network. This includes providing the information for all physicians, including specialists; hospitals; pharmacies; behavioral health providers; and long term services and supports providers, as appropriate.

- Provider's name as well as any group affiliation
- Street address(es)
- Telephone number(s)
- Website URL, as appropriate.
- Specialty, as appropriate.
- Whether the provider will accept new enrollees.
- The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competence training.
- Whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s) and equipment.
- Identification of qualified providers divided into specific provider and service types and specializations, including but not limited to: primary care physicians, specialists, hospital PCP groups, clinic settings, home and community-based services, outpatient therapy, residential substance use, youth residential services, inpatient mental health and residential substance use services, and FQHCs and RHCs in the service area. This shall include a child serving list that is both monitored and frequently updated to ensure viable options are identified and available for the Office of Juvenile Justice, the Department of Children and Family Services and the Louisiana Department of Education field staff. The MCO provider types shall be delineated by parish and zip code.
- Identification of any restrictions on the enrollee's freedom of choice among network providers
- Identification of hours of operation including identification of providers with non-traditional hours (Before 8 a.m. or after 5 p.m. or any weekend hours)

## Title Page

[New Page]

## Welcome

- MCO contact information, member services and hotline numbers and hours of operation
- Abbreviated overview covered benefits and services
- How to access care
  - How to find a doctor
  - How to get help from the MCO to access care
  - How to get specialized services such as specialized behavioral health or pharmacy services
  - After hours, urgent and emergent care
  - Nurse hotline
  - Behavioral health crisis line
  - Covered care through other providers – dental, vision, transportation, etc.
- How to choose a doctor
- What is a PCP
- MCO Value Added Benefits and how to access
- How to get help in other languages or formats

## How to use the directory

- Explain the different provider types
- Explain/provide a legend for the listings, including any complex terminology (such as the cultural competency training or the group affiliations).

## Individual provider details

<Name of Provider>		
Specialty	<List of Specialties, as appropriate>	
Group Affiliations	<List of Affiliations>	
Organization	<Primary organization>	
Location	<Street, City, Zip code> <Phone number> <Fax number> <website address>	Mailing Address (if different)
Accepting New Enrollees?	<Yes or No>	
Languages	<List of languages spoken/interpreted>	
Cultural Competency Training Completed	<Yes or No>	
Special Services or Accommodations	<List special services or accommodations>	
Hours of Operation	<Hours including non-traditional/after hours or weekend hours>	

## Denial Notices

Denial templates are to be followed with as little customization as possible. Any departures from the template must be submitted for review following normal material review procedures. Wells denial templates are updated periodically, based on changes to LDH, state and federal requirements. The latest template version, as well as bulletins offering notice guidance, can be found on the [Wells Compliance page](#) within the health plan representative page within the Provider and Plan Resources website.

## Wells Denial Template

[Company Header/logo and/Vendor Header/logo, if applicable]

[Denial Notice]

[Date]

[Enrollee Name]  
555 Healthy Avenue  
Anytown, LA Zip Code

Dear [Parent/Guardian or Enrollee Name]:

We are writing to tell you that your request for [amount of service, if applicable] for [service] and date(s) of service is [denied] and [Contractor Name] will not pay for the care. [[Vendor Name] reviews prior authorization for [service] on behalf of [Contractor Name], if applicable].

To find out why we won't pay, keep reading. If you think we made a mistake, you may ask for an appeal.

If you have questions, call [Contractor Name] at 1-XXX-XXX-XXXX. TTY users call 1-XXX-XXX-XXXX. This call is free. Your doctor also got a copy of this letter, so you should also talk to your doctor.

**Why won't [Contractor Name] pay for [amount of service, if applicable] for [service]?**

*This section should include a comprehensive explanation in plain language for why the request does not meet the guidelines/criteria for care. It should include ALL guidelines/criteria for the denial and how they were applied to the member's case. Do not limit to just one reason if there are multiple, but do not cloud the notice with criteria that were not a reason for denial.*

*General notice guidance:*

- *Include the criteria and activity the Contractor used to make the determination (requests made, medical records reviewed, etc.).*
  - *Explain how many of the factors listed, or what combination of those listed, must be present in order to establish medical necessity. Include a plain language explanation of medical necessity, as applicable.*
  - *If denied due to lack of information, the explanation must note the specific information needed to be considered for approval. Do not list information that you already have.*

[Contractor address, phone number, web address, etc.]

**Commented [LW1]:** FONT REQUIREMENTS, as per the settlement:

- Must be 12 point or greater for visually impaired.
- Avoid all caps.
- Any Font type as long as it is easily readable.
- Bolded terms in template do not have to be bolded, though it is strongly encouraged that the headers be bolded; italics are discouraged.

**Commented [LW2]:** Include a header at top of first page above the body to indicate if services are denied, partially denied.

**Commented [LW3]:** Keep date formatting consistent throughout.

**Commented [LW4]:** Include a salutation – "Dear member or parent or guardian of member" and a closing/signature at the end of the letter.

**Commented [LG5]:** Include amount of services, if applicable.

- Commented [LW6]:** •The specific service requested must be written in plain language. General categorization of type of service is not acceptable.
- Do not use procedure codes.

**Commented [LW7]:** "Denied" "must appear in the introductory paragraph.

**Commented [LG8]:** Include brief explanation of vendor's role, if applicable.

- Commented [LW9]:** •Keep phone number formatting consistent throughout.
- DH prefers "1" prior to the toll-free number.

**Formatted:** Font: Italic.

**Commented [LG10]:** Include amount of services, if applicable.

- Provide adequate information to assist in preparing for an appeal. If rules or regulations (federal and state) used to make the decision are cited, the regulation must be explained and the notice must include the language that relates how the facts of the recipient's situation compare/apply to the regulation cited. Include numbers for reference of rules.
- Where appropriate, break apart technical and complex information with bullets or numbering to make the information more readable and use clearly stated headers that will draw the member's attention.
- Summarize that, because of all the reasons stated, the Contractor does not think the care is medically necessary, unless the denial is administrative in nature.

You or someone legally authorized to do so, can ask for a free copy of the criteria, guidelines or any other information we used to make this decision by calling 1-XXX-XXX-XXXX.

Do you have questions? Call us at 1-XXX-XXX-XXXX. You may also want to talk to your doctor.

Does your doctor want to talk to someone about this decision? Your doctor can call [Contractor Reviewer Name] at 1-XXX-XXX-XXXX.

What can you do if you think [Contractor Name] made a mistake? If you think we made a mistake, you may ask for an appeal. If you want to request an appeal, you must do so within 60 calendar days from date of this notice.

How do you ask for an appeal?

How long does it take to make a decision about my appeal?

What if you need a fast decision?

If your condition is considered urgent, we may be able to make a decision about your appeal much sooner. You may need a fast decision if, by not getting the requested services, one of the following is likely to happen:

- You will be at risk of serious health problems, or you may die;
- You will have serious problems with your heart, lungs, or other body parts; or
- You will need to go into a hospital.

Your doctor must agree that you have an urgent need.

How do I continue to receive this service during my appeal?

Do you need help with this letter? Call [Contractor Name] at 1-XXX-XXX-XXXX.

If you need help in another language, call 1-XXX-XXX-XXXX (toll-free).

[Contractor address, phone number, web address, etc.]

**Commented [LW11]:** Added to comply with 42 CFR 438.404 and LDH RFP Section 13.4.2.

**Commented [LW12]:** INTERNAL APPEALS PROCESS:  
•For all organizations required to have an internal appeals process, the first denial notice must include this information.

STATE FAIR HEARING:

•For these organizations, the first denial notice must advise the member that he/she may request a State Fair Hearing after exhausting the internal appeals process, if he/she still disagrees.

•State Fair Hearing language must be included in the appeal denial letter.

•State Fair Hearing Contacts to be included in appeal denial letter:

- Mail: P.O. Box 4189 Baton Rouge, Louisiana 70821 - 4189
- Fax: (225) 219-9823
- Phone: (225) 342-5800 or (225) 342-0443
- Web: <http://www.adminlaw.state.la.us/FHH.htm>

**Commented [LW13]:** Note change: Now 60 calendar days from date of the notice.

**Commented [LW14]:** •MCOs must comply with contractual guidance on State Fair Hearing inclusion in notices of action. However, inclusion of the timeline to request a SFH is not required in the initial notice of adverse action.

•For MCOs, the entire Section 13.5.2.4 must be included with appeal denial letters. State Fair Hearing language should be included in the appeal denial letter. **NOTE: Contractors w/out an internal appeals process must only use the State Fair Hearing language.**

•MCOs must comply with contractual guidance on continuation of services pending resolution as per Section 13.5.2.7 of their contract. This language is prescribed in the template.

**Commented [LW15]:** Include all applicable means to request appeal (phone, fax, mail, etc.).

**Commented [LW16]:** Include the timeframe Contractor has to make a decision on the appeal. Standard appeal resolutions are within 30 calendar days. Use consistent formatting (e.g., 30 calendar days; thirty; thirty (30)).

**Commented [LG17]:** CFR requires resolution within 72 hours.

**Commented [LG18]:** CFR requires this language in the notice.

Para obtener ayuda para traducir o entender esta información, sírvase llamar al 1-XXX-XXX-XXXX o TDD/TTY 1-XXX-XXX-XXXX, entre 8 a.m. y 5 p.m.

Để được giúp phiên dịch hoặc hiểu phần này, xin gọi số 1-XXX-XXX-XXXX hoặc TDD/TTY 1-XXX-XXX-XXXX.

Sincerely,

**Commented [LW19]:** Include a closing signature.

[Contractor address, phone number, web address, etc.]

## Wells Partial Denial Template

[Company Header/logo and/Vendor Header/logo, if applicable]

[Partial Denial]

[Date]

[Enrollee Name]  
[Street Number/Address]  
[Any Town, LA Zip Code]

Dear [Parent/Guardian or Enrollee Name]:

We are writing to tell you that your request for [amount of service, if applicable] for [service and date(s) of service] is [partially denied] and [Contractor Name] will not pay for all of the care. [(Vendor Name) reviews prior authorization for [service] on behalf of [Contractor Name], if applicable].

To find out why we won't pay, keep reading. If you think we made a mistake, you may ask for an appeal.

**We will not pay for [amount of service, if applicable] for [denied service and date(s) of service], but [Contractor Name] will pay for the following care (if your doctor prescribes it):**  
1. List [amount of service, if applicable] and date of service that is approved  
2. List [amount of service, if applicable] and date of service that is approved

If you have questions, call [Contractor Name] at 1-XXX-XXX-XXXX, TTY users call 1-XXX-XXX-XXXX. This call is free. Your doctor also got a copy of this letter, so you should also talk to your doctor.

**Why won't [Contractor Name] pay for [service]?**

*This section should include a comprehensive explanation in plain language for why the request does not meet the guidelines/criteria for care. It should include ALL guidelines/criteria for the denial and how they were applied to the member's case. Do not limit to just one reason if there are multiple, but do not cloud the notice with criteria that were not a reason for denial.*

*General notice guidance:*

10000 Medical Avenue, Suite 220 | Baton Rouge, LA 70806 | 800-123-4567 (P) | 800-139-5236 (F) | www.contractor.com

**Commented [LW1]:** FONT REQUIREMENTS, as per the settlement:

- Must be 12 point or greater for visually impaired.
- Avoid all caps.
- Any Font type as long as it is easily readable.
- Bolded terms in template do not have to be bolded, though it is strongly encouraged that the headers be bolded; italics are discouraged.

**Commented [LW2]:** Include a header at top of first page above the body to indicate if services are denied, partially denied.

**Commented [LW3]:** Keep date formatting consistent throughout (e.g., March 28, 2018, 03/28/2018, 03/28/18, etc.).

**Commented [LW4]:** Include a salutation – "Dear member or parent or guardian of member" and a closing/signature at the end of the letter.

**Commented [LG5]:** Include amount of services, if applicable.

- Commented [LW6]:** •The specific service requested must be written in plain language. General categorization of type of service is not acceptable.
- Do not use procedure codes.

**Commented [LW7]:** "Partially denied" must appear in the introductory paragraph.

**Commented [LG8]:** Include brief explanation of vendor's role, if applicable.

**Commented [LG9]:** Include amount of services, if applicable. Should match amount of services and DOS in intro paragraph.

- Commented [LW10]:** •Keep phone number formatting consistent throughout.
- LDH prefers "1" prior to the toll-free number.



- Include the criteria and activity the Contractor used to make the determination (requests made, medical records reviewed, etc.).
  - Explain how many of the factors listed, or what combination of those listed, must be present in order to establish medical necessity. Include a plain language explanation of medical necessity, as applicable.
  - If denied due to lack of information, the explanation must note the specific information needed to be considered for approval. Do not list information that you already have.
- Provide adequate information to assist in preparing for an appeal. If rules or regulations (federal and state) used to make the decision are cited, the regulation must be explained and the notice must include the language that relates how the facts of the recipient's situation compare/apply to the regulation cited. Include numbers for reference of rules.
- Where appropriate, break apart technical and complex information with bullets or numbering to make the information more readable and use clearly stated headers that will draw the member's attention.
- Summarize that, because of all the reasons stated, the Contractor is does not think the care is medically necessary, unless the denial is administrative in nature.

You or someone legally authorized to do so, can ask for a free copy of the criteria, guidelines or any other information we used to make this decision by calling 1-XXX-XXX-XXXX.

Do you have questions? Call us at 1-XXX-XXX-XXXX. You may also want to talk to your doctor.

Does your doctor want to talk to someone about this decision? Your doctor can call [Contractor Reviewer Name] at 1-XXX-XXX-XXXX.

What can you do if you think [Contractor Name] made a mistake? If you think we made a mistake, you may ask for an appeal. If you want to request an appeal, you must do so within 60 calendar days from date of this notice.

How do you ask for an appeal?

How long does it take to make a decision about my appeal?

What if you need a fast decision?

If your condition is considered urgent, we may be able to make a decision about your appeal much sooner. You may need a fast decision if, by not getting the requested services, one of the following is likely to happen:

- You will be at risk of serious health problems, or you may die;
- You will have serious problems with your heart, lungs, or other body parts; or

**Commented [LW11]:** Added to comply with 42 CFR 438.404 and LDH RFP Section 13.4.2.

**Commented [LW12]:** INTERNAL APPEALS PROCESS:

•For all organizations required to have an internal appeals process, the first denial notice must include this information.

STATE FAIR HEARING:

•For these organizations, the first denial notice must advise the member that he/she may request a State Fair Hearing after exhausting the internal appeals process, if he/she still disagrees.

•State Fair Hearing language must be included in the appeal denial letter.

•State Fair Hearing Contacts to be included in appeal denial letter:

○ Mail: P.O. Box 4189 Baton Rouge, Louisiana 70821-4189

○ Fax: (225) 219-9823

○ Phone: (225) 342-5800 or (225) 342-0443

Web: <http://www.adminlaw.state.la.us/HH.htm>

**Commented [LW13]:** Note change: Now 60 calendar days from date the notice.

**Commented [LW14]:** •MCOs must comply with contractual guidance on State Fair Hearing inclusion in notices of action.

•For MCOs, the entire Section 13.5.2.4 must be included with appeal denial letters. State Fair Hearing language should be included in the appeal denial letter. **NOTE: Contractors w/out an internal appeals process must only use the State Fair Hearing language.**

•MCOs must comply with contractual guidance on continuation of services pending resolution as per Section 13.5.2.7 of their contract. This language is prescribed in the template.

**Commented [LW15]:** Include all applicable means to request appeal (phone, fax, mail, etc.).

**Commented [LW16]:** Include the timeframe Contractor has to make a decision on the appeal. Use consistent formatting (e.g., 30 calendar days; thirty; thirty (30)).

**Commented [LG17]:** CFR requires resolution within 72 hours.

• You will need to go into a hospital.  
Your doctor must agree that you have an urgent need.

**How do I continue to receive this service during my appeal?**

**Commented [LG18]:** CFR requires this language in the notice.

**Do you need help with this letter?** Call [Contractor Name] at 1-XXX-XXX-XXXX.

If you need help in another language, call 1-XXX-XXX-XXXX (toll-free).

Para obtener ayuda para traducir o entender esta información, sírvase llamar al 1- XXX-XXX-XXXX o TDD/TTY 1-XXX-XXX-XXXX, entre 8 a.m. y 5 p.m.

Để được giúp phiên dịch hoặc hiểu phần này, xin gọi số 1-XXX-XXX-XXX hoặc TDD/TTY 1-

Sincerely,

**Commented [LW19]:** Include a closing signature.

## Wells Denial Template, Pharmacy, Hep-C

[Company Header/logo and/Sub-Contractor Header/logo, if applicable]

[Denial Notice]

[Date]

[Enrollee Name]  
123 Healthy Avenue  
Anytown, LA Zip Code

Dear [Parent/Guardian or Enrollee Name]:

We are writing to tell you that your request for [Hep C Drug and date(s) of service] is [denied] and [Health Plan Name] will not pay for the care.

To find out why we won't pay, keep reading. If you think we made a mistake, you may ask for an appeal.

If you have questions, call [Health Plan Name] at 1-XXX-XXX-XXXX. TTY users call 1-XXX-XXX-XXXX. This call is free. Your doctor also got a copy of this letter, so you should also talk to your doctor.

### Why won't [Health Plan Name] pay for [Hep C drug]?

*This section should include a comprehensive explanation in plain language for why the request does not meet the guidelines/criteria for care. It should include ALL guidelines/criteria for the denial and how they were applied to the member's case. Do not limit to just one reason if there are multiple, but do not cloud the notice with criteria that were not a reason for denial.*

#### General Hep C pharmacy notice guidance:

- Include the criteria and activity the Contractor used to make the determination (requests made, medical records reviewed, etc.).
  - If denied due to lack of information, the explanation must note the specific information needed to be considered for approval and whether all or a combination are needed. Do not list information that you already have.
- Provide adequate information to assist in preparing for an appeal. If rules or regulations (federal and state) used to make the decision are cited, the regulation must be explained and the notice must include the language that relates how

[Contractor address, phone number, web address, etc.]

**Commented [LW1]:** FONT REQUIREMENTS, as per the

settlement:

- Must be 12 point or greater for visually impaired.
- Avoid all caps.
- Any Font type as long as it is easily readable.
- Bolded terms in template do not have to be bolded, though it is strongly encouraged that the headers be bolded; italics are discouraged.

**Commented [LW2]:** Include a header at top of first page above the body to indicate if services are denied, partially denied.

**Commented [LW3]:** Keep date formatting consistent throughout.

**Commented [LW4]:** Include a salutation – “Dear member or parent or guardian of member” and a closing/signature at the end of the letter.

**Commented [LW5]:** “Denied” “must appear in the introductory paragraph.

**Commented [LW6]:** •Keep phone number formatting consistent throughout.  
•LDH prefers “1” prior to the toll-free number.

*the facts of the recipient's situation compare/apply to the regulation cited. Include numbers for reference of rules.*

- *Where appropriate, break apart technical and complex information with bullets or numbering to make the information more readable and use clearly stated headers that will draw the member's attention.*
- *Summarize that, because of all the reasons stated, the Contractor is does not think the care is medically necessary.*

You or someone legally authorized to do so, can ask for a free copy of the criteria, guidelines or any other information we used to make this decision by calling 1-XXX-XXX-XXXX.

Do you have questions? Call us at 1-XXX-XXX-XXXX. You may also want to talk to your doctor.

Does your doctor want to talk to someone about this decision? Your doctor can call [Contractor Reviewer Name] at 1-XXX-XXX-XXXX.

What can you do if you think [Health Plan Name] made a mistake? If you think we made a mistake, you may ask for an appeal. If you want to request an appeal, you must do so within 30 days from date of this notice.

How do you ask for an appeal?

How long does it take to make a decision about my appeal?

What if you need a fast decision?

If your condition is considered urgent, we may be able to make a decision about your appeal much sooner. You may need a fast decision if, by not getting the requested services, one of the following is likely to happen:

- You will be at risk of serious health problems, or you may die;
- You will have serious problems with your heart, lungs, or other body parts; or
- You will need to go into a hospital.

Your doctor must agree that you have an urgent need.

Do you need help with this letter? Call [Health Plan Name] at 1-XXX-XXX-XXXX.

If you need help in another language, call 1-XXX-XXX-XXXX (toll-free).

Para obtener ayuda para traducir o entender esta información, sírvase llamar al 1-XXX-XXX-XXXX o TDD/TTY 1-XXX-XXX-XXXX, entre 8 a.m. y 5 p.m.

Để được giúp phiên dịch hoặc hiểu phần này, xin gọi số 1-XXX-XXX-XXXX hoặc TDD/TTY 1-

[Contractor address, phone number, web address, etc.]

**Commented [LW7]:** Added to comply with 42 CFR 438.404 and LDH RFP Section 13.4.2.

**Commented [LW8]:** INTERNAL APPEALS PROCESS:  
•For all organizations with an internal appeals process (current MCOs: Aetna, ACLA, AMG, LHCC, UHCC, MCNA), the first denial notice must include the internal appeals process.

•MCOs must comply with contractual guidance on State Fair Hearing inclusion in the first denial notice. This language must advise the member that he/she may request a State Fair Hearing after exhausting the MCO's internal appeal process, if he/she still disagrees.

STATE FAIR HEARING:

•For MCOs, the first denial notice must advise the member that he/she may request a State Fair Hearing after exhausting the internal appeals process, if he/she still disagrees.

•State Fair Hearing language must be included in the appeal denial letter.

•State Fair Hearing Contacts to be included in appeal denial letter:

- Mail: P.O. Box 4189 Baton Rouge, Louisiana 70821 - 4189
- Fax: (225) 219-9823
- Phone: (225) 342-5800
- Web: <http://www.adminlaw.state.la.us/HH.htm>

**Commented [LW9]:** Note change: Now 30 days from date of the notice.

**Commented [LW10]:** •MCOs must comply with contractual guidance on State Fair Hearing inclusion in notices of action.

•For MCOs, the entire Section 13.5.2.4 must be included with appeal denial letters. State Fair Hearing language should be included in the appeal denial letter. **NOTE: Contractors w/out an internal appeals process must only use the State Fair Hearing language.**

•MCOs must comply with contractual guidance on continuation of services pending resolution as per Section 13.5.2.7 of their contract. This language is not prescribed in the template, but must be included as applicable. Insert where appropriate.

**Commented [LW11]:** Include all applicable means to request appeal (phone, fax, mail, etc.).

**Commented [LW12]:** Include the timeframe Contractor has to make a decision on the appeal. Use consistent formatting (e.g., 30 days; thirty days; thirty (30) days).

Sincerely,

**Commented [LW13]:** Include a closing signature.

[Contractor address, phone number, web address, etc.]

## Wells PDHC Template

### Notice of Denial

[Date]

To the Parents or Guardian of:  
[Enter Member's First and Last Name]  
[Member's Address]  
[Member's City, State Zip Code]

Dear Parents or Guardian of [Member's Name]:

We are writing to tell you that your request for Pediatric Day Health Care (PDHC) and transportation for dates of service [Dates of Service] is denied and [Health Plan] will not pay for the care.

To find out why we won't pay, keep reading. If you think we made a mistake, you may ask for an appeal.

If you have questions, call [Health Plan] at [1-XXX-XXX-XXXX] or [TDD/TTY XXX]. This call is free. Your doctor also got a copy of this letter, so you can also talk to your doctor.

#### Why won't [Health Plan] pay for PDHC and transportation for [Dates of Service]?

The name of the criteria and/or regulation used to make the decision is: Pediatric Day Health Care Provider Manual.

The specific reason for the decision is: Your child's doctor asked for PDHC and transportation for [him/her]. The Manual above has rules about these services for members under 21 years old. They say your child must:

- Have a medically complex condition and needs both skilled care and any type of therapy by a licensed nurse on an ongoing basis to:
  - preserve and maintain health;
  - prevent death;
  - treat or cure disease;
  - improve disabilities or other adverse health conditions; and/or
  - prolong life.
- Be stable for outpatient medical services in a home or community-based setting.

We have reviewed the following records from [Provider Name]:

Records reviewed from [Provider Name] submitted on [Date]— entire record

- [Health Plan to insert provider record details. Here is an example of the type of language that should be included: When your child was having seizures, she qualified for services. The records we reviewed show that her seizures are controlled on Keppra. She is no longer having seizures. Therefore, she no longer



*needs monitoring for seizures. The records show that she does not need to be on oxygen. She does not have heart or lung disease, or any medical problems as described above. Based on the PDHC Provider Manual and medical records, she no longer needs the services her doctor asked for.]*

**Commented [DL1]:** This is specific to the case that was used to help create the template. The information here will vary based on provider input.

Because of all the reasons stated, [Health Plan] does not think the care is medically necessary.

**Do you have questions?** Call us at [1-XXX-XXX-XXXX] or [TTY XXX]. You may also want to talk to your doctor.

**Does your doctor want to talk to someone about this decision?** Your doctor can talk to the doctor who made this decision by calling [1-XXX-XXX-XXXX].

**What can you do if you think [Health Plan] made a mistake?**

If you think we made a mistake, you may ask for an appeal. If you want to request an appeal, you must do so within 30 calendar days from receipt of this notice.

To file an appeal, you can call us at [1-XXX-XXX-XXXX], [TTY XXX] or you can send your appeal to:

[Health Plan]  
Attn: Grievances & Appeals Department  
[Address]  
[City, State, Zip]

**How long does it take to make a decision about my appeal?**

We will review your appeal and send a written decision within 30 calendar days of our receipt of your appeal.

You can do the appeal yourself, or you can choose someone else to do the appeal for you. Your representative can be someone you trust such as a lawyer, a family member or friend. You, your representative, or your doctor also has the right to give us information about your appeal. That information can be in person or in writing. You or your representative can also see your case file both before and during the appeal.

**What if you need a fast decision?**

If your condition is considered urgent, we may be able to make a decision about your appeal much sooner. You may need a fast decision if, by not getting the requested services, one of the following is likely to happen:

- You will be at risk of serious health problems, or you may die;
- You will have serious problems with your heart, lungs, or other body parts; or
- You will need to go into a hospital.

Your doctor must agree that you have an urgent need. We will review your appeal and send a written decision within 3 calendar days of our receipt of your appeal.

**State Fair Hearing**

Once you have completed [Health Plan's] appeal process, and you still disagree with our decision, you can request a State Fair Hearing. Instructions on how to file a State Fair Hearing will be sent with your appeal decision letter.

**Do you need help with this letter?** Call [Health Plan] at [1-XXX-XXX-XXXX], [TTY XXX].

If you need help in another language, call [1-XXX-XXX-XXXX], [TTY XXX] (toll-free).

Para obtener ayuda para traducir o entender esta información, sírvase llamar al [1-XXX-XXX-XXXX, TTY XXX], entre 7 a.m. y 7 p.m.

Để được giúp phiên dịch hoặc hiểu phần này, xin gọi số [1-XXX-XXX-XXXX] hoặc [TDD/TTY XXX] trong khoảng từ 7 giờ sáng - 7 giờ chiều.

Sincerely,

[Reviewer Name, Title]  
[Health Plan]

CC: [Provider Name]



## Lock-In

The lock-in templates are to be followed with as little customization as possible. Any departures from the template must be submitted for review following normal material review procedures. MCOs will be notified in the event the lock-in templates are updated.

## Lock-In Notification Template

[MCO Address Block]

### Lock-In Decision Letter

[Member Address Block]

Date: [date]

Dear [Member Name]:

Your medical records show that you are not using your Medicaid coverage in a way which is best for your health. [Health Plan name] is placing you in a special program that will help you use your Medicaid in a healthier way. You are being placed in the [Health Plan Pharmacy Lock-In Program name] Program. This program can assist you in managing your medications to stay healthy.

Under this program, you must choose: one (1) pharmacy. The pharmacy lock-in will not apply to medications from specialty pharmacies. The pharmacy you pick will be in charge of your prescriptions beginning XX/XX/XXXX. You will still get all of the other services you are getting from your Health Plan right now.

You may select a pharmacy from the list below or a different pharmacy as your lock-in pharmacy.

1. [Pharmacy 1 name]/ Pharmacy address/Phone number
2. [Pharmacy 2 name]/Pharmacy address/Phone number
3. [Pharmacy 3 name]/Pharmacy address/Phone number

If you choose a different pharmacy, we will let you know if the lock-in pharmacy you picked is approved. In order to pick a lock-in pharmacy by phone, please call 1-(XXX)XXX-XXXX before XX/XX/XXXX between [hours]. If you want to pick your pharmacy by mail, please mail back the enclosed form to: [Health Plan name and address.] If we do not hear from you, a pharmacy will be chosen for you. You will be locked-in to the first pharmacy on the list above. We will also notify you by mail of which pharmacy you can use.

This change will **NOT HAPPEN** until XX/XX/XXXX (30 days from the date you receive this notice) to give you, or anyone you want to represent you, time to talk about this decision with [Health Plan name] OR to request an appeal.

Sincerely,

[Lock-In Contact]

[Health Plan Lock-In Contact]

1-(xxx) xxx-xxxx

Toll Free Phone Number

1-(xxx) xxx-xxxx

Fax Number [optional]

**What can I do if I disagree with the [Health Plan's] decision?**

If you disagree with the decision, you (or someone you select to help you) may ask for an appeal. If you want to request an appeal, you must do so within 30 days from receipt of this notice.

**What happens if you ask for an appeal?**

- You tell [Health Plan] why you think the decision to limit your pharmacy is incorrect.
- If you want someone to help you with the appeal, you must give them written permission.
- Until a decision is made about your appeal, you can keep using your current pharmacy.
- After the appeal, if you disagree with the appeal decision you can request a State Fair Hearing. If you accept this decision and do not file an appeal, you cannot later request a State Fair Hearing.

**How do you ask for an appeal?**

Give us all of the information listed here:

Your name	
Your address	
Your telephone number	
Your date of birth, Social Security number, or member ID number	
Why you think you should be able to keep using your current pharmacy or pharmacies	

Send your request to [Health Plan]. You can file an appeal by mail, phone or fax.

**Mail:** [Health Plan address]

**Phone:** [Health Plan toll free number]

**Fax:** [Health Plan toll free fax number]

**How long does it take to make a decision about my appeal?**

Most decisions are made within x days of requesting an appeal.

**Do you need help with this letter?** Call [Health Plan] at [Health Plan toll free number.] If you need help in another language, call 1-888-xxx-xxxx (toll-free).

Para obtener ayuda para traducir o entender esta información, sírvase llamar al **1- 888-xxx-xxxx** o TDD/TTY **1-877-xxx-xxxx**, entre 8 a.m. y 5 p.m.

Để được giúp phiên dịch hoặc hiểu phần này, xin gọi số **1-866-595-8133** hoặc TDD/TTY **1-877-xxx-xxxx** trong khoảng từ 8 giờ sáng - 5 giờ chiều.

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### Lock-In Provider Choice Form

**Instructions:** You may choose a pre-selected pharmacy or write in your lock-in pharmacy choice.

The pharmacy lock-in will not apply to medications from specialty pharmacies. All other services covered by

[Health Plan name] will still be available to you.

I, \_\_\_\_\_ select the pharmacy listed below as my lock-in pharmacy.  
(Member's Name)

1. [Pharmacy 1 name]/ Pharmacy address/Phone number

2. [Pharmacy 2 name]/Pharmacy address/Phone number

3. [Pharmacy 3 name]/Pharmacy address/Phone number

4. Pharmacy name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Pharmacy phone number: \_\_\_\_\_

Signature \_\_\_\_\_  
(Member's signature)

Date \_\_\_\_\_

Note: You can pick your lock-in pharmacy by phone or mail. You can call [Health Plan Lock-In Contact] at 1-XXX-XXX-XXXX between [hours] with your lock-in pharmacy choice. You can also mail your lock-in pharmacy choice to [Health Plan name and address].

## Lock-In Provider Approval Template

[MCO Address Block]

### Lock-In Provider Approval Letter

[Member Address Block]

Date: [date]

Dear [Member Name]:

Your Lock-In pharmacy is approved. It is listed below. If the pharmacy below does not have a medication or meet all of your needs, you may call [Health Plan] at 1-XXX-XXX-XXXX between [hours]. This does not include medications from a specialty pharmacy. The goal of your pharmacy Lock-In is to help you use your medications in a healthier way.

[Lock-In pharmacy name]

[Address Line 1]

[Address Line 2]

[Phone number]

Sincerely,

[Lock-In Contact]

[Health Plan Lock-In Contact]

1-(xxx) xxx-xxxx

Toll Free Phone Number

1-(xxx) xxx-xxxx

Fax Number

## Lock-In Provider Auto-Assignment Template

[MCO Address Block]

### Lock-In Assignment Letter

[Member Address Block]

Date: [date]

Dear [Member Name]:

You have been placed in the [Health Plan Pharmacy Lock-In Program Name]. We mailed you a letter to let you know about the program. In the letter, you were asked to pick one pharmacy. Since we did not get your pharmacy choice, you have been assigned to [Pharmacy Name]. It is listed below. If the pharmacy below does not have a medication or meet all of your needs, you may call [Health Plan] at 1-XXX-XXX-XXXX between [hours]. This does not include medications from a specialty pharmacy. The goal of your pharmacy Lock-In is to help you use your medications in a healthier way.

[Lock-In pharmacy name]

[Address Line 1]

[Address Line 2]

[Phone number]

Sincerely,

[Lock-In Contact]

[Health Plan Lock-In Contact]

1-(xxx) xxx-xxxx

Toll Free Phone Number

1-(xxx) xxx-xxxx

Fax Number

## Lock-In Provider Denial Template

[MCO Address Block]

### Lock-In Provider Denial Letter

[Member Address Block]

Date: [date]

Dear [Member Name]:

After a review of your records, your Lock-In pharmacy choice is denied. You have been assigned to [Pharmacy Name]. It is listed below. If the pharmacy below does not have a medication or meet all of your needs, you may call [Health Plan] at 1-XXX-XXX-XXXX between [hours]. This does not include medications from a specialty pharmacy. The goal of your pharmacy Lock-In is to help you use your medications in a healthier way.

[Lock-In Pharmacy name]

[Address Line 1]

[Address Line 2]

[Phone number]

Sincerely,

[Lock-In Contact]

[Health Plan Lock-In Contact]

1-(xxx) xxx-xxxx

Toll Free Phone Number

1-(xxx) xxx-xxxx

Fax Number

## Lock-In Removal Template

[MCO Address Block]

### Lock-In Removal Letter

[Member Address Block]

Date: [date]

Dear [Member Name]:

After a review of your records, you will be removed from the [Health Plan Pharmacy Lock-In] Program. Your pharmacy lock-in will end on [date]. We will continue to look at your records. If you need more help managing your medications, you will be placed back into the [Health Plan Pharmacy Lock-In] Program.

Sincerely,

[Lock-In Contact]

[Health Plan Lock-In Contact]

1-(xxx) xxx-xxxx

Toll Free Phone Number

1-(xxx) xxx-xxxx

Fax Number



## Quarterly Report

This template can also be found online at [www.ldh.la.gov/MME](http://www.ldh.la.gov/MME).

The template for the quarterly report can be found on the [Provider and Plan Resources Managed Care Reporting Deliverables](#) page.

The report has two parts. The first is for reporting events which have occurred in the reporting period. The second is for reporting materials distributed during the reporting period.

### Events

Column A: Event Date – Should be in a DD/MM/YYYY format. This helps distinguish similar events from one another.

Column B: Event Start Time – Time should be entered using a twenty-four hour clock format. It will auto-format into a twelve hour clock.

Column C: Event End Time – As with start time, this should be entered using a twenty-four hour clock format. It will auto-format into a twelve hour clock.

Note: Entering times in a twenty-four hour format gives the health plan the opportunity to find improperly entered data before submission, as it will not auto-format correctly. Improperly entered times cannot be used in calculations, which inhibits analysis of the report.

Column D: Name of Event – Not a required field. Should be used if the event has a formal name. If left blank it will auto-fill using the event date, host and city.

Column E: Event Location: Street Address – The street number and street name where the event is being held.

Column F: Event Location: City – The city where the event is being held.

Column G: Event Location: Parish

Column H: Type of Event – The template has a drop down menu for this field. This gives a common vocabulary for all health plans, assisting in analysis of the report.

Non-Event Sponsorship: Any sponsorship that is not associated with an event, but where an organization or entity is being sponsored rather than an event.

Charity Walk/Run: An event where representatives of the health plan take part in a charity walk or run and are wearing clothing that includes the health plan's logo. This should NOT be used when a health plan is an exhibitor or sponsor of the walk or run.

Marketing Only Event: Any event where there is not direct communication between a health plan marketing representative and a member of the target population, but attendees of the event are distributed marketing materials. (Examples: parades, some conferences)

Mass Media: A distribution of information via mass media, does not include interviews (i.e. newspapers, magazines and other periodicals, radio, television, the internet, public

transportation advertising, billboards and other media outlets). A description of the run should be included in the 'Brief description of Event' field.

**Marketing Materials Restock:** Any event where a health plan marketing representative restocks supplies of marketing materials left at a static location (examples: provider offices, retail outlets, libraries) but does not set up an informational table and generally does not have direct communication with a member of the target population.

**Presentation:** Any event where a health plan representative gives a formal presentation, whether it is to providers, members or the general public.

**Community Meeting:** A collaborative meeting with community stakeholders attended by a health plan representative in local communities to coordinate efforts to improve some predefined outcome (Examples: coalition meetings, social service network meetings, task forces, event planning meetings, etc.)

**Interview:** An interview conducted with a mass media outlet

**Exhibit booth (Health/Resource Fair):** Any event where the health plan is one of multiple vendors set up to distribute information to the public.

**Informational Table:** Any event where a health plan marketing representative sets up as they might at a health or resource fair, but without other vendors present.

**Other:** Any event that does not fit one of the above descriptions. Please describe what makes other event types inappropriate in the 'Brief description of Event' field.

**Column I: Target Audience** - The template has a drop down menu for this field. This gives a common vocabulary for all health plans, assisting in analysis of the report.

**Members Only:** All attendees are members or their guardians.

**Contracted Providers Only:** The event is intended only for contracted providers.

**Other:** Any audience that is not made up solely of members or solely of contracted providers.

**Column J: Marketing Plan Reference** – Used to track the progression of the marketing plan. This field should cite the specific marketing or member education goal and strategy being addressed by the event. If the event does not fall under any current section of the marketing plan a revised marketing plan, including the event, should be submitted to LDH prior to the event. (The second strategy listed for the first marketing goal in the marketing plan would be referenced I.a.i.2.)

**Column K: Brief Description of Event** – Events with 'other' selected for the event type should give details as to what about the event does not conform to one of the established categories. This enables the tracking of 'other' events in order to determine if a new event type is needed as an option.

**Column L: Sponsorship Amount:** Reports the monetary or value of an in-kind donation or sponsorship to individuals, organizations or other entities.

**Column M: Event Host/Sponsored Entity: Organization/Business/Individual:** This field helps distinguish similar events from one another.

Column N: Materials Distributed at Event – Please list the LDH-ID number for any item distributed at an event. If a material does not have an LDH-ID number, please submit it for review and discontinue distribution until it has been approved.

Column O: Number of Attendees – Data in this field should reflect the number of attendees with whom there was direct contact at exhibit booths or informational tables; the number of marketing materials distributed at a marketing-only event or marketing materials restock; the estimated number of impressions for a mass media event; or the number of attendees of a presentation or community meeting.

Column P: Comments (Optional Field)

### Materials

All materials distributed for marketing or member education during the last quarter should be listed here.

Column A: Material Title – The title of the material or a brief description of the promotional item.

Column B: LHD-ID – At review each material is assigned an ID number by LDH.

Column C: Material Type - The template has a drop down menu for this field. This gives a common vocabulary for all health plans, assisting in analysis of the report.

Health Education: Includes, but is not limited to topic specific: posters, flyers, brochures, lesson plans, parents' guides, magazines, checklists, fact sheets, tips and children's books.

Marketing: Includes, but is not limited to: concepts of advertising, public service announcements, printed publications, other broadcast and electronic messages designed to increase awareness and interest in the managed care organization. This includes any information that references the managed care organization, is intended for general distribution and is produced in a variety of print, broadcast or direct marketing mediums.

Member Education: Includes, but is not limited to: member handbooks, identification cards, provider directories, form letters, mass mailings, e-mails, member letters and newsletters.

Promotional Item: An article of merchandise used in a marketing a managed care organization.

Other: Any item distributed that does not fit one of the above categories. Please describe the item in detail in the 'Comments' section.

Column D: Marketing Plan Reference – Used to track the progression of the marketing plan. This field should cite the specific marketing or member education goal and strategy being addressed by the material. If the event does not fall under any current section of the marketing plan a revised marketing plan, including the material, should be submitted to LDH. (The second strategy listed for the first marketing goal in the marketing plan would be referenced I.a.i.2.)

Column E: Language – The template has a drop down menu for this field. This gives a common vocabulary for all health plans, assisting in analysis of the report.

Not Applicable

English

Spanish

Vietnamese

English & Spanish (on the same form)

Other: Please indicate language in the comments field, if none of the above are appropriate.

Column F: Quantity Distributed – Data should reflect the number distributed statewide during the reporting quarter.

Column G: Comments – Details should be given for any materials where ‘other’ was selected for material type or language. This enables the tracking of ‘other’ materials and helps determine if a new type or language should be added to the drop down list.

### Analysis

The number of, duration of and attendance at events as well as sponsorship dollars vis-à-vis potential enrollees in a region is examined to determine if the health plan is achieving an equitable level of marketing throughout the state.

Likewise, the number of, duration of and attendance at events vis-à-vis enrolled members in a region is examined to determine if the health plan is achieving an equitable level of member education throughout the state.

### Comparison Chart

The comparison chart will be compiled by LDH staff and may include any or all of the following: value added benefits approved by LDH, contractually obligated services, contact information for the MCOs, HEDIS data, CAHPS data or NCQA rankings. Please note: Unlike prior revisions of the comparison chart, MCOs will not be consulted prior to release of an updated comparison chart. The document will be compiled using value added benefits information submitted for approval prior to the publication date.

### Marketing Complaints

This template can also be found online at [www.ldh.la.gov/MME](http://www.ldh.la.gov/MME).



# Marketing Complaint Submission Form

Revision 10/2018

FOR LDH USE ONLY	
STAGE OF REVIEW	DATE
<input type="checkbox"/> Form Received at LDH	
<input type="checkbox"/> Investigation Begins	
<input type="checkbox"/> Sanctions Applied	
<input type="checkbox"/> Response Sent to Complainant	
<input type="checkbox"/> Investigation Closed	
Marketing Complaint Tracking #:	

COMPLAINANT CONTACT INFORMATION		
Complainant Name/Title/Organization:		
Address:		
Phone:	E-mail:	Fax:
COMPLAINT DETAILS		
Parties to the Alleged Violation: <i>(violator, witnesses and others)</i>		
Date/Time/Frequency of Alleged Violation:		
Location of Alleged Violation: <i>(facility name including location – address, unit, room, floor)</i>		
Narrative/specifics of alleged violation: <i>(Please attach any documentation to support this allegation and attach additional pages if more space is needed)</i>		
Why is this alleged violation a violation of the Marketing Policy and Procedures? <i>(Please include citations to specific policies and procedures)</i>		
What harm has resulted due to this alleged violation? <i>(such as misrepresentation, unfair advantage gained)</i>		
What is the complainant's expectation/desire for resolution/remedy, if any?		
LDH FINDINGS		
LDH Investigator Signature: <i>(at completion of investigation)</i>		
Date:		